NAVHOSPJAXINST 6230.3C
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FEB 12 2008

NAVHOSPJAX INSTRUCTION 6230.3C

From: Commanding Officer

Subj: STAFF IMMUNIZATION AND SCREENING PROGRAM

Ref: (a) BUMEDINST 6230.15A
(b) BUMEDINST 6224.8
(c) OSHA Occupational Exposure to Bloodborne Pathogens 29 CFR 1910.1030
(d) CDC Healthcare Worker Immunizations, MMWR 1997; 46(RR-18)
(e) CDC Recommended Adult Immunization Schedule United States, October 2005-September 2006, MMWR 2005; 54(40); Q1-Q4
(f) NEHC-TM OM 6260 Feb 2001
(g) NAVHOSPJAXINST 5300.1
(h) NAVHOSPJAXINST 6224.1C
(i) NAVHOSPJAXINST 6220.6D
(j) NAVHOSPJAXINST 5211.6

Encl: (1) Contract Staff Immunization Documentation Form
(2) Reservist Immunization Documentation Form
(3) Student Immunization Documentation Form
(4) Volunteer Immunization Documentation Form

1. Purpose. To establish the Immunization and Chemoprophylaxis Policy for Naval Hospital Jacksonville (NAVHOSPJAX) and its Naval Branch Health Clinics (NBHCs) staff members. This instruction summarizes evaluation requirements specific for the protection of both patients and staff from communicable diseases. For specific requirements for the Military Vaccination Program principles, procedures, policies, and responsibilities for the immunization program and military and international health regulations and requirements, refer to reference (a), located on the NHJAX intranet homepage, under Frequently Used Links → Instructions → Other → Immunization Protocol.

2. Cancellation. NAVHOSPJAXINST 6230.3B

3. Background. References (a) and (b) establish program requirements as set by the Department of Defense and the Department of the Navy. References (c) through (j) provide

additional guidance on the protection of patients and staff from communicable diseases. Pre-placement immunization requirements, along with periodic monitoring are essential to ensure the mission of NAVHOSPJAX is not compromised by preventable nosocomial infections among patients or staff.

4. Scope. The immunization and chemoprophylaxis requirements set forth in this instruction apply to all Active Duty (AD) military, Reservists, civil service, contractors, students, and volunteers attached to NAVHOSPJAX and its NBHCs and personnel from other institutions who are involved in medical or dental care at NAVHOSPJAX and its NBHCs.

5. Action

a. All NAVHOSPJAX and its NBHCs personnel are required to maintain immunization and testing status in compliance with references (a) through (j). Additional immunizations may be required for deployment, depending on locale. Enclosures (1) through (4) list required documentation of immunizations for contract staff, Reservists, students and volunteers respectively.

b. Certain civilian employees may be required to receive immunizations as a condition of their employment or participation in a particular assignment. In such cases, failure to voluntarily receive the immunizations may result in non-adverse or adverse action taken, but in no case will immunizations be involuntarily administered.

c. Directors and Department Heads are to ensure that their staff comply with the provisions of this instruction.

d. All NAVHOSPJAX and its NBHCs personnel must report to Occupational Health upon check-in for verification of required immunizations and testing, per reference (g). All personnel must provide copies of immunization records and laboratory results as required.

e. If an AD staff member's record is lost, assume the individual received standard immunizations administered at entry into military service, unless there is an objective reason to believe otherwise. Base decisions for future immunizations on assumed date of last immunizations.

f. Occupational Health will maintain overall responsibility for the staff immunization program. The following departments

are responsible for tracking and ensuring assigned staff groups are in compliance with all required immunizations/testing/ screening:

(1) ACTIVE DUTY STAFF - Family Practice/Immunization Department

(2) CIVILIAN STAFF - Occupational Medicine

(3) RESERVISTS - Cognizant Reserve Activity

(4) CONTRACT STAFF - Contracting Office

(5) RED CROSS VOLUNTEERS - Red Cross Office

(6) ALL OTHER VOLUNTEERS - Public Affairs Office

(7) ALL STUDENTS - Respective Departments where students are assigned

(8) NAVAL BRANCH HEALTH CLINIC (NBHC) STAFF - Respective Naval Branch Health Clinics

g. The Laboratory will make the results of all relevant serological testing available to the cognizant tracking department.

h. The Immunization Clinic at NAVHOSPJAX or at its NBHCs will provide the required immunizations for eligible personnel.

i. Management Information Department (MID) will provide necessary assistance to automate immunization tracking and reporting.

j. Directors and Department Heads are to ensure that individuals obtain required immunizations/testing/screening as identified by specific cognizant tracking department.

k. Drilling Reservists may obtain the required immunizations during regular Immunization Clinic hours at NAVHOSPJAX or one of the NBHCs.

l. Contracts will be written or amended so that the contractor provides and submits pre-placement documentation of necessary immunizations. Personal Service Contractors once hired, will receive required immunizations/testing/screening at NAVHOSPJAX or one of the NBHCs.

m. The Infection Control Committee and the Preventive Medicine Department will provide notification to the Head, Occupational Health/Preventive Medicine Services Department of any proposed changes in required immunizations.

n. Persons must be observed for 15-20 minutes after being immunized.

6. Patient Information. Directors and Department Heads will ensure their staff manages Protected Health Information in accordance with reference (j). See reference (a) for electronic documentation requirements.

7. Immunizations

Immunizations	Staff Requirements	Dosage
Hepatitis A	Health Care Workers (HCWs) and daycare workers having contact with active cases, laboratory workers who are at risk of exposure and designated food handlers. Military, civilian and contract workers as required in deployment situation.	Series of 2 vaccines
Hepatitis B	HCWs and all workers at-risk of exposure to Bloodborne Pathogen (BBP), deployed or deploying personal as appropriate.	Series or history of 3 vaccines and quantitative post-immunization testing*
Influenza	All Staff	Annually
Measles, Mumps, Rubella (MMR)	HCWs	Series of 2 vaccines or positive titers**
Tetanus-Diphtheria (Td) or Tdap	All Staff	At least every 10 years
TST or TB screen	All Staff	Annually***
Varicella	HCWs	History of disease, series of 2 vaccines, or positive titer.

* Quantitative post-vaccination serosusceptability testing should be done for anti-HBs at 1 month or more after administering dose three. A test result of ≥ 10 miu/ml indicates immunity. Repeat vaccine series and titer one time if low or no immunity. In the case of persistent negative titer, provide counseling by licensed practitioner regarding implications of non-response.
** Two lifetime doses of MMR or positive serologic test results. Persons born in 1957 or earlier are presumed to be immune through infection. Unless there is reason to suspect otherwise (example, childhood in a developing country, childhood immunizations not administered), a childhood dose of MMR vaccine may be assumed. It is reasonable to obtain rubella antibody titer for females of childbearing age as part of the pre-employment examination.
*** Documentation of 2 previous TSTs is required for pre-employment/placement, or if converter, required documentation and negative CXR within 1 year. If a documented negative TST result within the previous 12 months is noted, a single TST can be administered. If period between documented TST and time of employment/placement is more than 12 months, the 2-step TST testing method is required.

/s/
R. C. BONO

Distribution:
NHJAX Intranet

CONTRACT WORKER IMMUNIZATION/SCREENING DOCUMENTATION FORM

AFTER contract award, but prior to performing services, the contract health care worker shall have this form completed by a licensed medical practitioner.

COPIES OF TITER LABORATORY RESULTS MUST BE ATTACHED TO THIS FORM

IMMUNIZATION/ SCREENING	REQUIRED DOCUMENTATION	DATES and RESULTS (To be completed by examining licensed practitioner)	
VARICELLA (CHICKENPOX) All HCWs.	Reliable history of chickenpox disease, **OR**	Hx:	
	2-dose vaccine series, **OR**	Dates of Shots: 1. 2.	
	Positive titers.	Titers:	
MEASLES/ MUMPS/ RUBELLA (MMR) All HCWs.	MMR live virus 2-life time doses (one may be assumed), **OR** Persons born in 1957 or earlier are presumed to be immune through infection. **OR**	Dates of Shots: 1. 2.	
	Positive titers.	Titers:	
HEPATITIS B HCWs at-risk of exposure to Bloodborne Pathogen (BBP).	HBV 3-dose vaccine series **AND** positive titer, **OR** HBV 3-dose vaccine series with negative titer **AND** repeat 3-dose HBV series with repeat titer **AND** in the case of persistent negative titer, counseling by licensed practitioner regarding implications of non-response.	Dates of Shots: 1. 2. 3. Titer:	Dates of Repeat Shots: 1. 2. 3. Titer: Counseling provided:
TETANUS/ DIPHTHERIA All HCWs.	Tetanus/Diphtheria (TD) booster, **OR**	Date of TD booster:	
	Tetanus/Diphteria/Pertussis (Tdap) within the preceding 10 years.	Date of Tdap:	
TUBERCULOSIS All HCWs.	Two-step Tuberculin Skin Test (TST), **OR** One Blood Assay for Mycobacterium Tuberculosis (BAMT), **OR** An annual evaluation if known TST reactor and negative CXR within 1 year	2-Step TST dates: 1st test: 1st result: 2nd test: 2nd result: CXR date: Pos: Neg:	BAMT date: Result: Date of last annual eval:
LATEX	Latex sensitivity screening questionnaire administered.	Date of evaluation: Results: Sensitive Not sensitive	
	If latex sensitivity suspected, follow with appropriate allergy testing.	Date of test: Results:	

_____ [Name of Contract Health Care Worker] has presented for a physical examination. He/She is applying for the position of _____ [please enter job title]. He/She was examined on _____ [date] and found to be in good health, meeting the immunization/ screening required above, and not suffering from any medical condition or infectious disease that prevents his/her ability to perform services for the position described above. YES NO [Please circle either YES or NO.]

Provider's Signature: _____ Provider's Name: _____

Address: _____

Phone Number: _____ Date: _____

*The facility shall identify any **incumbent** HCWs who are not required to complete this documentation.

Privacy Act Statement: The authority to request this information is contained in 5 USC 301, Department Regulations. The principal purpose of the information is data collection.

RESERVIST IMMUNIZATION/SCREENING DOCUMENTATION FORM

COPIES OF TITER LABORATORY RESULTS MUST BE ATTACHED TO THIS FORM

IMMUNIZATION/ SCREENING	REQUIRED DOCUMENTATION	DATES and RESULTS (To be completed by examining licensed practitioner)	
VARICELLA (CHICKENPOX) All HCWs.	Reliable history of chickenpox disease, **OR**	Hx:	
	2-dose vaccine series, **OR**	Dates of Shots: 1. 2.	
	Positive titers.	Titers:	
MEASLES/ MUMPS/ RUBELLA (MMR) All HCWs.	MMR live virus 2-life time doses (one may be assumed), **OR** Persons born in 1957 or earlier are presumed to be immune through infection. **OR**	Dates of Shots: 1. 2.	
	Positive titers.	Titers:	
HEPATITIS B HCWs at-risk of exposure to Bloodborne Pathogen (BBP).	HBV 3-dose vaccine series **AND** positive titer, **OR** HBV 3-dose vaccine series with negative titer **AND** repeat 3-dose HBV series with repeat titer **AND** in the case of persistent negative titer, counseling by licensed practitioner regarding implications of non-response.	Dates of Shots: 1. 2. 3. Titer:	Dates of Repeat Shots: 1. 2. 3. Titer: Counseling provided:
TETANUS/ DIPHTHERIA All HCWs.	Tetanus/Diphtheria (TD) booster, **OR**	Date of TD booster:	
	Tetanus/Diphteria/Pertussis (Tdap) within the preceding 10 years.	Date of Tdap:	
TUBERCULOSIS All HCWs.	Two-step Tuberculin Skin Test (TST), **OR** One Blood Assay for Mycobacterium Tuberculosis (BAMT), **OR** An annual evaluation if known TST reactor and baseline CXR subsequent to positive TST.	2-Step TST dates: 1st test: 1st result: 2nd test: 2nd result: CXR date: Pos: Neg:	BAMT date: Result: Date of last annual eval:
LATEX	Latex sensitivity screening questionnaire administered.	Date of evaluation: Results: Sensitive Not sensitive	
	If latex sensitivity suspected, follow with appropriate allergy testing.	Date of test: Results:	

Notes: _____

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Patient's Name:	**Rank:**	**Sex:**
SSN/Identification Number:	**Work location:**	**Date of Birth:**

Privacy Act Statement: The authority to request this information is contained in 5 USC 301, Department Regulations. The principal purpose of the information is data collection.

STUDENT IMMUNIZATION/SCREENING DOCUMENTATION FORM

COPIES OF TITER LABORATORY RESULTS MUST BE ATTACHED TO THIS FORM

IMMUNIZATION/ SCREENING	REQUIRED DOCUMENTATION	DATES and RESULTS (To be completed by examining licensed practitioner)	
VARICELLA (CHICKENPOX) All HCWs.	Reliable history of chickenpox disease, **OR**	Hx:	
	2-dose vaccine series, **OR**	Dates of Shots: 1. 2.	
	Positive titer.	Titer:	
MEASLES/ MUMPS/ RUBELLA (MMR) All HCWs.	MMR live virus 2-life time doses (one may be assumed), **OR** Persons born in 1957 or earlier are presumed to be immune through infection. **OR**	Dates of Shots: 1. 2.	
	Positive titers.	Titers:	
HEPATITIS B HCWs at-risk of exposure to Bloodborne Pathogen (BBP).	HBV 3-dose vaccine series **AND** positive titer, **OR** HBV 3-dose vaccine series with negative titer **AND** repeat 3-dose HBV series with repeat titer **AND** in the case of persistent negative titer, counseling by licensed practitioner regarding implications of non-response.	Dates of Shots: 1. 2. 3. Titer:	Dates of Repeat Shots: 1. 2. 3. Titer: Counseling provided:
TETANUS/ DIPHTHERIA All HCWs.	Tetanus/Diphtheria (TD) booster, **OR**	Date of TD booster:	
	Tetanus/Diphteria/Pertussis (Tdap) within the preceding 10 years.	Date of Tdap:	
TUBERCULOSIS All HCWs.	Two-step Tuberculin Skin Test (TST), **OR** One Blood Assay for Mycobacterium Tuberculosis (BAMT), **OR** An annual evaluation if known TST reactor and negative CXR within 1 year.	2-Step TST dates: 1st test: 1st result: 2nd test: 2nd result: CXR date: Pos: Neg:	BAMT date: Result: Date of last annual eval:
LATEX	Latex sensitivity screening questionnaire administered.	Date of evaluation: Results: Sensitive Not sensitive	
	If latex sensitivity suspected, follow with appropriate allergy testing.	Date of test: Results:	

Notes: _____

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Patient's Name:	**Rank:**	**Sex:**
SSN/Identification Number:	**Work location:**	**Date of Birth:**

Privacy Act Statement: The authority to request this information is contained in 5 USC 301, Department Regulations. The principal purpose of the information is data collection.

VOLUNTEER IMMUNIZATION/SCREENING DOCUMENTATION FORM

COPIES OF TITER LABORATORY RESULTS MUST BE ATTACHED TO THIS FORM

IMMUNIZATION/ SCREENING	REQUIRED DOCUMENTATION	DATES and RESULTS (To be completed by examining licensed practitioner)	
VARICELLA (CHICKENPOX) All HCWs.	Reliable history of chickenpox disease, **OR**	Hx:	
	2-dose vaccine series, **OR**	Dates of Shots: 1. 2.	
	Positive titers.	Titers:	
MEASLES/ MUMPS/ RUBELLA (MMR) All HCWs.	MMR live virus 2-life time doses (one may be assumed), **OR** Persons born in 1957 or earlier are presumed to be immune through infection. **OR**	Dates of Shots: 1. 2.	
	Positive titers.	Titers:	
HEPATITIS B HCWs at-risk of exposure to Bloodborne Pathogen (BBP).	HBV 3-dose vaccine series **AND** positive titer, **OR** HBV 3-dose vaccine series with negative titer **AND** repeat 3-dose HBV series with repeat titer **AND** in the case of persistent negative titer, counseling by licensed practitioner regarding implications of non-response.	Dates of Shots: 1. 2. 3. Titer:	Dates of Repeat Shots: 1. 2. 3. Titer: Counseling provided:
TETANUS/ DIPHTHERIA All HCWs.	Tetanus/Diphtheria (TD) booster, **OR**	Date of TD booster:	
	Tetanus/Diphteria/Pertussis (Tdap) within the preceding 10 years.	Date of Tdap:	
TUBERCULOSIS All HCWs.	Two-step Tuberculin Skin Test (TST), **OR** One Blood Assay for Mycobacterium Tuberculosis (BAMT), **OR** An annual evaluation if known TST reactor and negative CXR within 1 year	2-Step TST dates: 1st test: 1st result: 2nd test: 2nd result: CXR date: Pos: Neg:	BAMT date: Result: Date of last annual eval:
LATEX	Latex sensitivity screening questionnaire administered.	Date of evaluation: Results: Sensitive Not sensitive	
	If latex sensitivity suspected, follow with appropriate allergy testing.	Date of test: Results:	

Notes: _____

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Patient's Name:	**Rank:**	**Sex:**
SSN/Identification Number:	**Work location:**	**Date of Birth:**

Privacy Act Statement: The authority to request this information is contained in 5 USC 301, Department Regulations. The principal purpose of the information is data collection.